City of Oakland, Human Services Department - MSSP
150 Frank H. Ogawa Plaza
4th floor, Oakland, CA, 94612
Fax : 510-238-7696
Case Manangement CLIENT REFERRAL FORM

Print Form

Date: _____

Site Number: _____ MSSP Number: _____

Enrollment Date _____ SSN _____ Medicare/RRB Number _____ County Code _____ Aide Code _____

Medi-Cal Number:_____ Issue Date: _____

Client Name: _____ Gender:_____
Last Name, First Name, Middle Initial

Date of Birth: _____ Age: _____ Lives Alone? _____ Partner/Spouse/ Significant Other Status: _____

Client Address:

_____
Street Address

_____
City, State, Zip

_____ _____
Telephone (Home) Telephone (Cell)

Client Mailing Address (if different from above):

_____
Address

_____
City, State, Zip

Race Origin: _____

Ethnic Background: _____

Level of Care: _____

Major Language Spoken: _____

Other: _____

Years of School: _____

Emergency Contact Information:

_____
Name

_____
Street Address

_____
City, State, Zip

_____ _____
Telephone # (Work) Telephone # (Home)

Relationship of Emergency Contact: _____

Any Animals? _____

Number of Steps to front door/access: _____

Physician Information:

_____
Name

_____
Street Address

_____
City, State, Zip

_____ _____
Telephone Fax

Referral Source Information:

_____
Name

_____
Street Address

_____
City, State, Zip

_____
Telephone

Relationship/Referral Source: _____

Any firearms in the home? If yes, describe: _____
Is prospective enrollee aware of referral? _____

DIAGNOSIS	DATE OF ONSET	MEDICATIONS	DOSE METHOD	FREQUENCY

Hospitalization last 12 months: (i.e. number, length, facility)

Reason: _____

SNF or ICF last 12 months: (i.e. number, length, facility)

Lives With: _____ Living Conditions: _____

Formal Supports: _____

Informal Supports: _____

Psycho/Social Problems: _____

Currently receiving assistance from a Medicaid Waiver program: Yes_____ No_____

Incontinence:

Bowel No_____ Yes_____ How frequent _____

Bladder No_____ Yes_____ How frequent _____

Comments: _____

Impaired Hearing: No_____ Yes_____ Degree: (i.e. hearing aide) _____

Speech Impaired: No_____ Yes_____ Degree: _____

Impaired Vision: No_____ Yes_____ Degree: (i.e. glasses) _____

Other Impairments: No_____ Yes_____ Type: _____

Comments: _____

FUNCTIONAL IMPAIRMENT: **(1)** Independent **(2)** Standby or minimal assistance
(3) Frequent assistance **(4)** Totally dependent

	1 2 3 4	Comments: kind & amount of assistance needed
a. Transferring	☐ ☐ ☐ ☐	
b. Toileting	☐ ☐ ☐ ☐	
c. Bathing	☐ ☐ ☐ ☐	
d. Grooming	☐ ☐ ☐ ☐	
e. Dressing	☐ ☐ ☐ ☐	
f. Ambulation	☐ ☐ ☐ ☐	
g. Stairs	☐ ☐ ☐ ☐	
h. Eating	☐ ☐ ☐ ☐	
i. Housekeeping	☐ ☐ ☐ ☐	
j. Transportation	☐ ☐ ☐ ☐	
k. Food Preparation	☐ ☐ ☐ ☐	
l. Grocery Shopping	☐ ☐ ☐ ☐	
m. Money Management	☐ ☐ ☐ ☐	
n. Special Care Needed: (wound, colostomy care, oxygen/IPPB, skin care/decubitus, etc.) Specify:		
_____	☐ ☐ ☐ ☐	
_____	☐ ☐ ☐ ☐	
_____	☐ ☐ ☐ ☐	
_____	☐ ☐ ☐ ☐	
o. Other: Specify:		
_____	☐ ☐ ☐ ☐	

Treatments	1 2 3 4	Problems:
a. Medications	☐ ☐ ☐ ☐	
b. Injections	☐ ☐ ☐ ☐	
c. Oxygen	☐ ☐ ☐ ☐	
d. Other	☐ ☐ ☐ ☐	

EMOTIONAL CONDITIONS: **(1) No impairment (2) Mild (3) Moderate (4) Severe**

	1	2	3	4	Comments:
a. Abusive	☐	☐	☐	☐	_____
b. Anxiety	☐	☐	☐	☐	_____
c. Combative	☐	☐	☐	☐	_____
d. Confusion	☐	☐	☐	☐	_____
e. Delusion	☐	☐	☐	☐	_____
f. Depression	☐	☐	☐	☐	_____
g. Disoriented	☐	☐	☐	☐	_____
h. Impaired Judgment	☐	☐	☐	☐	_____
i. Memory Loss	☐	☐	☐	☐	_____
j. Social Isolation	☐	☐	☐	☐	_____
k. Wanders	☐	☐	☐	☐	_____
l. Withdrawn	☐	☐	☐	☐	_____
m. Other (Specify)					
_____	☐	☐	☐	☐	_____

n. Evidence or indications of abuse, neglect or exploitation

Yes_____ No_____ Type, degree: _____

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o. Past history of Psychiatric Care: _____

_____

p. History of substance abuse: _____

_____

q. Is client a smoker? _____

Is anyone considering placement? Yes_____ No_____ Who_____

Does applicant want to remain at/return home? Yes_____ No_____

Is client appropriate for MSSP case management? Yes_____ No_____

ICF or SNF eligible? Yes_____ No_____

Comments: _____

_____

_____

_____

Print Form